MDR Tracking Number: M5-05-0155-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 9-8-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the prescription medications and electrical stimulator were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity was the only issue involved in this medical dispute. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 6-14-04 to 7-1-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 18th day of March 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

Enclosure: IRO Decision

March 3, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0155-01
TWCC #:
Injured Employee:
Requestor:
Respondent: ESIS
MAXIMUS Case #: TW05-0023

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in internal medicine and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he injured his back when he lifted a pan of turkeys. An MRI of the lumbar spine performed 6/12/03 showed evidence of an L4-5, and L5-S1 disc herniation, central spinal stenosis noted at the L3-4, L4-5 levels, and mild disc bulges at the L2-3 and L3-4 levels. On 6/12/03 the patient underwent a sensory nerve conduction threshold testing of the lower extremities and was reportedly diagnosed with profound sensory loss and right sided very severe hypoesthetic condition at the superficial peroneal nerve. Diagnoses for this patient's condition have included acute cervical, lumbosacral, and SI strain/sprain with bilateral radiculopathy. Treamtent for this patient's condition has included Matrix treatments, medications consisting of Vicodin, Soma, and Xanax, an electrical stimulator, and physical therapy consisting of traction, active and passive range of motion, manual therapy, theraputic exercises, neuromuscular reeducation, stabilization and a home exercise program.

Requested Services

Carisoprodol, Alprazolam, Cyclobenzaprine, Hydrocodone, Vioxx, and an A4595-electrial stimulator from 6/14/04 – 7/1/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter of Medical Necessity 8/24/04
2. Peer Review 3/26/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a male who sustained a work related injury to his back on ___. The MAXIMUS physician reviewer indicated that the patient underwent extensive treatment with medications, physical therapy, removal from work, and epidural steroid injections. The MAXIMUS physician reviewer noted that diagnostic testing revealed disc bulges and herniations. The MAXIMUS physician reviewer indicated that the patient had been treated with medications and electrical stimulation. The MAXIMUS physician reviewer explained that treatment with opiates, such as hydrocodone, is not effective or indicated for treatment of chronic back pain. The MAXIMUS physician reviewer indicated that there are no studies demonstrating the efficacy of long term use of muscle relaxers, such as carisoprodol and cyclobenzaprine, in the treatment of chronic lower back pain. The MAXIMUS physician reviewer noted that the records do not support the diagnosis of ongoing back spasm. The MAXIMUS physician reviewer explained that the alprazolam class of medication is addictive and not indicated for the treatment of chronic back pain. The MAXIMUS physician reviewer indicated that sufficient evidence on the long term efficacy of NSAIDS, such as Vioxx, in the treatment of chronic low back pain is lacking. The MAXIMUS physician reviewer explained that given the adverse effects of long term use of any NSAID, their use in chronic low back pain is not recommended. The MAXIMUS physician reviewer also explained that there is no evidence to support the use of electrical stimulation in the treatment of chronic low back pain.

Therefore, the MAXIMUS physician consultant concluded that the Carisoprodol, Alprazolam, Cyclobenzaprine, Hydrocodone, Vioxx, and an A4595-electrial stimulator from 6/14/04 – 7/1/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department